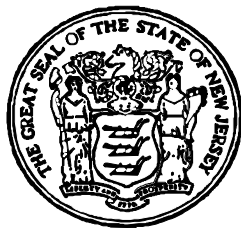


HEALTH CLAIM FRAUD REFERRAL FORM

OIFP-3A (01/01)



State of New Jersey
Office of Insurance Fraud Prosecutor
P.O. Box 094
Trenton, NJ 08625

For OIFP use only:

OIFP Case # _____/_____/_____

Intake # _____

Investigator _____

PART I

INSURANCE CO. _____

ADDRESS _____

TELEPHONE _____

CONTACT PERSON _____

E-MAIL ADDRESS _____

DATE REPORTED _____

NAIC COMPANY # _____

D.O.S. _____

CLAIM # _____

POLICY # _____

TYPE OF COVERAGE (Check appropriate box)

HEALTH (INDEMNITY) ☐ HEALTH (MEDICAID) ☐

HEALTH (HMO) ☐ DENTAL ☐

OTHER _____

STATUS (Check appropriate box)

PENDING ☐ PAID - IN FULL ☐

DENIED ☐ PAID - IN PART ☐

OTHER ☐

AMOUNT PD \$ _____ DATE/RANGE PD _____

IF PENDING OR DENIED, EITHER IN FULL OR IN PART

THE DOLLAR AMOUNT OF THE PENDING OR DENIED
CLAIM: \$ _____

INSURED/SUBJECT/PROVIDER (CIRCLE)

LAST _____ FIRST _____ MIDDLE _____

STREET _____ CITY _____ STATE-ZIP _____

HOME PH. _____ WORK PH. _____ D.O.B. _____

S.S./T.I.N # _____ D.L. # _____

LICENSE # _____ STATE _____

BUSINESS NAME _____ TIN # _____

TYPE OF PROVIDER (Check appropriate box)

MD ☐ DO ☐ PHD ☐ DDS ☐ DMD ☐ HOSPITAL ☐ OUTPATIENT FACILITY ☐ PHYSICAL THERAPY ☐ MD/CHIR

PRACTICE ☐ DME SUPPLIER ☐ HOME HEALTH ☐ PHARMACIST ☐ SURGI-CENTER ☐ MSW ☐

OTHER _____

TAX ID #s USED: _____

SPECIALTY

ALLERGIST ☐ ANESTHESIOLOGY ☐ CARDIOLOGY ☐ CHIROPRACTIC ☐ DERMATOLOGY ☐ EMERGENCY MEDICINE
ENDOCRINOLOGY ☐ ENDODONTIST ☐ ENT ☐ EPIDEMIOLOGY ☐ FAMILY MEDICINE ☐ GASTROENTEROLOGY
GENERAL PRACTICE ☐ IMMUNOLOGY ☐ INFECTIOUS DISEASE ☐ INTERNAL MEDICINE ☐ NEONATOLOGY ☐ NEUROLOGY
☐ OBSTETRICS/GYNECOLOGY ☐ ONCOLOGY ☐ OPHTHALMOLOGY ☐ OPTOMETRY ☐ ORAL SURGEON ☐ ORTHODONTIST
☐ ORTHOPEDICS ☐ OTOLARYNGOLOGY ☐ PEDIATRICS ☐ PODIATRY ☐ PERIODONTIST ☐ PLASTIC SURGERY
PROSTIDONTIST ☐ PSYCHIATRY ☐ RADIOLOGY ☐ SURGERY ☐ UROLOGY ☐ WEIGHT LOSS ☐ OTHER _____

January 2001

PROVIDER

LAST: _____ FIRST: _____ MIDDLE: _____
DBA, LLC, PA OR GROUP PRACTICE NAME: _____
STREET: _____ CITY: _____ STATE: _____ ZIP: _____
TELEPHONE #: _____ DOB: _____ SS #: _____
STATE LICENSE #: _____

DOES THIS CLAIM FORM PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. 17:33A-4?

YES ☐ NO ☐

IF YES, LIST OTHER RELATED CLAIM NUMBERS, INDICATE STATUS OF OTHER RELATED CLAIMS, AND ATTACH COPIES OF OTHER REFERRALS, IF APPLICABLE:

ARE YOU AWARE OF ANY OTHER COMPANIES PURSUING RECOVERIES AGAINST THIS SUBJECT?

YES ☐ NO ☐

IF YOU CHECKED "YES", PLEASE COMPLETE THE FOLLOWING:

NAME OF OTHER COMPANY	INVESTIGATOR	CONTACT NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

PART II

PROVISIONS OF N.J.S.A. 17:33A-4 RELATING TO FALSE CLAIMS THAT MAY HAVE BEEN VIOLATED:
(CHECK APPROPRIATE BOX OR BOXES)

- ☐ **a(1) - presents false information:** KNOWINGLY PRESENTS OR CAUSES TO BE PRESENTED ANY WRITTEN OR ORAL STATEMENT CONTAINING ANY FALSE MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(1)
- ☐ **a(2) - makes a false statement:** KNOWINGLY PREPARES OR MAKES ANY WRITTEN OR ORAL STATEMENT CONTAINING ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(2)
- ☐ **a(3) - conceals relevant information:** CONCEALS OR KNOWINGLY FAILS TO DISCLOSE THE OCCURRENCE OF AN EVENT WHICH AFFECTS ANY PERSON'S INITIAL OR CONTINUED RIGHT OR ENTITLEMENT TO PAYMENT OF A CLAIM. N.J.S.A. 17:33A-4A(3)
- ☐ **b - conspires with another:** ASSISTS, CONSPIRES WITH OR URGES ANY PERSON OR PRACTITIONER TO VIOLATE ANY PROVISION(S) OF THIS ACT. N.J.S.A. 17:33A-4B. (IF SO, SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED _____).
- ☐ **c - knowingly benefits from insurance fraud:** DUE TO THE ASSISTANCE, CONSPIRACY OR URGING OF ANOTHER, KNOWINGLY BENEFITS, DIRECTLY OR INDIRECTLY, FROM THE PROCEEDS DERIVED FROM A VIOLATION OF THIS ACT. N.J.S.A. 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED _____).

- ☐ **d - involvement of hospital:** AN OWNER, ADMINISTRATOR OR EMPLOYEE OF ANY HOSPITAL WHO KNOWINGLY ALLOWS THE USE OF THE FACILITIES OF THE HOSPITAL BY ANY PERSON IN FURTHERANCE OF A SCHEME OR CONSPIRACY TO VIOLATE ANY OF THE PROVISION(S) OF THE ACT N.J.S.A 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED _____).
- ☐ **e - using or being a runner:** A PERSON OR PRACTITIONER FOR PECUNIARY GAIN, DIRECTLY OR INDIRECTLY SOLICITS:
 - ☐ ANY PERSON OR PRACTITIONER TO ENGAGE, EMPLOY OR RETAIN A PERSON TO MANAGE ADJUST OR PROSECUTE, ANY CLAIM OR CAUSE OF ACTION FOR DAMAGES.
 - ☐ ANY PERSON TO BRING CAUSES OF ACTION TO RECOVER DAMAGES FOR PERSONAL INJURIES/DEATH.
 - ☐ ANY PERSON TO MAKE A CLAIM FOR PERSONAL INJURY PROTECTION BENEFITS. N.J.S.A. 17:33/4E.

NOTE: IF THE INSURANCE COMPANY PAID MONEY FOR THE CLAIM(S), OBTAIN ALL CLAIMS CHECKS AND SUBMIT TO OIFP AS SOON AS PRACTICABLE AFTER SUBMISSION OF THIS REFERRAL FORM.

PART III

1. INDICATE THE PARTICULAR FACTS AND CIRCUMSTANCES, INCLUDING WHAT THE CLAIMANT DID AND FRAUD INDICATORS, WHICH LED YOU TO SUSPECT THAT THE ACT WAS VIOLATED, AS CHECKED ABOVE. (MERELY STATING "SEE ATTACHED" FILE OR DOCUMENT IS NOT ACCEPTABLE WITHOUT SPECIFIC DESIGNATION OF PAGE AND LINE REFERENCED, BUT EXTRA SHEETS MAY BE USED TO MORE COMPLETELY EXPLAIN.)*

2. LIST ALL FALSE OR MISLEADING STATEMENTS MADE TO THE INSURANCE CARRIER, OR INFORMATION OMITTED, AND INDICATE ON WHICH CLAIM DOCUMENT EACH STATEMENT OR OMISSION IS MADE: (FOR EXAMPLE, ACORD FORM, AFFIDAVIT OF VEHICLE THEFT, APPRAISAL, AFFIDAVIT OF NO INSURANCE, RECORDED STATEMENT, POLICE ACCIDENT REPORT, RECEIPT, ETC.)*

3. INDICATE THE EVIDENCE WHICH CORROBORATES THE SUSPICIOUS FACTS AND CIRCUMSTANCES INDICATED IN PARAGRAPH 1. ABOVE: (FOR EXAMPLE, WITNESS STATEMENT, DOCUMENTARY EVIDENCE WHICH DIRECTLY CONTRADICTS A STATEMENT OR OMISSION MADE IN THE CLAIM PROCESS, AN EXPERT'S REPORT, OTHER APPARENT MISREPRESENTATION MADE TO SUPPORT THE CLAIM WHICH TEND TO INDICATE THAT THE MISREPRESENTATION OR OMISSION WAS NOT MERELY A MISTAKE).*

4. SPECIFY ANY EVIDENCE WHICH WOULD TEND TO INDICATE THAT A LICENSED PROFESSIONAL MAY HAVE KNOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AND HIS EMPLOYER:

(FOR EXAMPLE, POLICE OFFICER, MEDICAL SERVICE PROVIDER, ATTORNEY, INSURANCE PRODUCER/AGENT, INSURANCE CARRIER EMPLOYEE, AUTO REPAIR FACILITY EMPLOYEE, APPRAISER, OR CLAIMS ADJUSTER).*

* For each document listed in support of the allegation of fraud, please attach an exact copy of the original. In addition, as to all documents attached to this form, please complete the attached Certification of Custodian of Records.

CERTIFICATION OF CUSTODIAN OF RECORDS

I certify that the records identified herein are originals or exact copies of the records made by a person with actual knowledge in the regular course of business at the time the activity took place. If additional records later become known or available, I shall promptly provide them to the Office of Insurance Fraud Prosecutor. I certify that the foregoing statements by me are true. I am aware that if any of the foregoing statements made by me are willfully false I am subject to punishment.

(List each document in this space or reference a separate attached listing)

Custodian of Records
(Full Name and Title)

Dated:

PART IV

COMPLETE THE FOLLOWING ONLY IF THERE ARE ADDITIONAL SUBJECTS OF THE INVESTIGATION

INFORMATION REGARDING ANY ADDITIONAL INSURED:

LAST _____ FIRST _____ MIDDLE _____
STREET _____ CITY _____ STATE/ZIP _____
HOME PH. _____ WORK PH. _____ S.S. # _____
D.L. # _____

CLAIMANT #1 (IF OTHER THAN INSURED/SUBJECT)

LAST _____ FIRST _____ MIDDLE _____
STREET _____ CITY _____ STATE/ZIP _____
HOME PH. _____ WORK PH. _____ S.S. # _____
D.L. # _____

CLAIMANT #2

LAST _____ FIRST _____ MIDDLE _____
STREET _____ CITY _____ STATE/ZIP _____
HOME PH. _____ WORK PH. _____ S.S. # _____
D.L. # _____

CLAIMANT #3

LAST _____ FIRST _____ MIDDLE _____
STREET _____ CITY _____ STATE/ZIP _____
HOME PH. _____ WORK PH. _____ S.S. # _____
D.L. # _____

PART V

COMPLETE THE FOLLOWING ONLY IF LICENSED PROFESSIONALS ARE SUBJECTS OF THE INVESTIGATION

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER _____ (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST _____ FIRST _____ MIDDLE _____ LIC # _____
EMPLOYER _____ PHONE # _____
ADDRESS _____ TAX ID # _____
ADDRESS (CONT.) _____ D.O.B. _____ S.S. # _____

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER _____ (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST _____ FIRST _____ MIDDLE _____ LIC # _____
EMPLOYER _____ PHONE # _____
ADDRESS _____ TAX ID # _____
ADDRESS (CONT.) _____ D.O.B. _____ S.S. # _____

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER _____ (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST _____ FIRST _____ MIDDLE _____ LIC # _____
EMPLOYER _____ PHONE # _____
ADDRESS _____ TAX ID # _____
ADDRESS (CONT.) _____ D.O.B. _____ S.S. # _____

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER _____ (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST _____ FIRST _____ MIDDLE _____ LIC # _____
EMPLOYER _____ PHONE # _____
ADDRESS _____ TAX ID # _____
ADDRESS (CONT.) _____ D.O.B. _____ S.S. # _____